



ConsumersUnion®
PUBLISHER OF CONSUMER REPORTS

The Affordable Care Act: The First Year

**DISCOVER WHAT THE NEW LAW
MEANS FOR YOU AND YOUR FAMILY**

A Note About Using This Guide:

What's a Grandfathered Plan?

You'll see references to "grandfathered" and "non-grandfathered" (or new) plans. Put simply, grandfathered plans are those that existed when the health-care reform law was signed on March 23, 2010, and that have not made significant reductions in benefits causing them to lose that status. If plans lose their grandfathered status, they must meet the new provisions described in this guide. We've noted where new rules do not apply to grandfathered plans. Check with your insurer or human resources representative for more information about your plan's status.

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What's going on with the new health-care law? What does it really do for you and your family? If you're confused and want to know the facts, you're certainly not alone.

That's where Consumers Union comes in. Since its founding 75 years ago, Consumers Union, the publisher of Consumer Reports, has been focused on providing consumers with easy-to-understand comparative information so that they can make the best decisions in the marketplace. We know firsthand

that the health-care marketplace is one where consumers have deep concerns. We've been especially motivated on the issue by the personal stories we've heard and surveys we've conducted involving real people with real problems. They want access to safe and affordable health care for themselves and their families. Indeed, six out of 10 Americans we surveyed in April 2009 said they were concerned about going bankrupt because of an illness or accident. And in fact, catastrophic medical bills are still among the main causes of bankruptcy in the U.S.

The new health-care law, the Patient Protection and Affordable Care Act, includes several key consumer benefits that can help alleviate some of these problems. But you need to know about the benefits—and when they become active—to actually take advantage of them.

Because our current health-care system is so complex, making big changes takes time. So the new law is being phased in, starting with its signing on March 23, 2010, and continuing until January 1, 2014, when all the pieces are scheduled to be in place. We've created this consumer guide to help you understand your options after one year of the law's being in effect—similar to what we did at the six-month mark—and we've included resources on the Web where you can get additional reliable information.

We hope you find this guide useful. Copies are available for download on our website, at www.ConsumerReportsHealth.org/insurance, and in Spanish at www.ConsumerReportsenEspanol.org/salud.

We welcome your feedback, your partnership, and your collaboration as we work together to address the concerns and advance the interests of America's health-care consumers.

A handwritten signature in black ink that reads "Jim Guest". The signature is fluid and cursive, with the first letters of the first and last names being capitalized and prominent.

Jim Guest
PRESIDENT & CEO
Consumers Union
Publisher of Consumer Reports



"We no longer have to lose sleep worrying about heading for bankruptcy when we hit the lifetime cap on our health insurance policy."

—Bill, of Santa Clara, Calif., who was until recently quickly approaching a lifetime limit on his policy for treatment of his daughter's spinal muscular atrophy.

If You Have Health Insurance

New patient's rights

Health insurance benefits are regulated differently by each of the 50 states, so your rights depend on where you live. These new rules give patients new protections and apply to all plans across the country, with few exceptions.

How it works:

- Insurers can't impose a lifetime limit on your benefits, meaning you don't have to worry about your coverage maxing out when you most need it.
- Annual benefit limits are phasing out too, rising from \$750,000 to \$2 million per year before they are abolished in 2014.
- If you disagree with a benefit decision by your insurer, new independent appeals give consumers a standard, reliable way to dispute coverage decisions.
- Health insurers can't arbitrarily cancel your coverage if you get sick.
- You can now obtain preventive care such as annual exams and cancer screenings with no out-of-pocket costs.

The fine print:

- Some plans received temporary waivers delaying the requirement that they end annual benefit limits.
- Ending lifetime and annual limits applies only to "essential" health benefits as determined by the federal government.
- Insurers can still cancel your policy for fraud or intentional misrepresentation.
- New rights of appeal, free preventive care, and phased out annual limits don't apply to many grandfathered plans.

Sick children can't be denied coverage

How it works:

- Children under age 19 can't be denied coverage because of their health status.
- Insurers can't exclude coverage for treatment related to a child's pre-existing condition.
- insurance for them may not be affordable.
- State laws may restrict access to new coverage for sick kids to specific open-enrollment periods.

The fine print:

- Until 2014, insurers can still charge higher premiums for sick children, so
- Insurers in some states have threatened to stop selling child-only policies.



"The new law gives us peace of mind that we'll always be able to find health coverage for our daughter."

—Nydia, of Brentwood, Calif., who has a daughter born with a heart defect.

If You're Uninsured or Losing Your Coverage

Some 50 million Americans are uninsured, in part because of the recent recession and resulting layoffs. Recent changes help extend coverage to certain groups, but reforms that will extend coverage to millions more Americans don't begin until 2014.

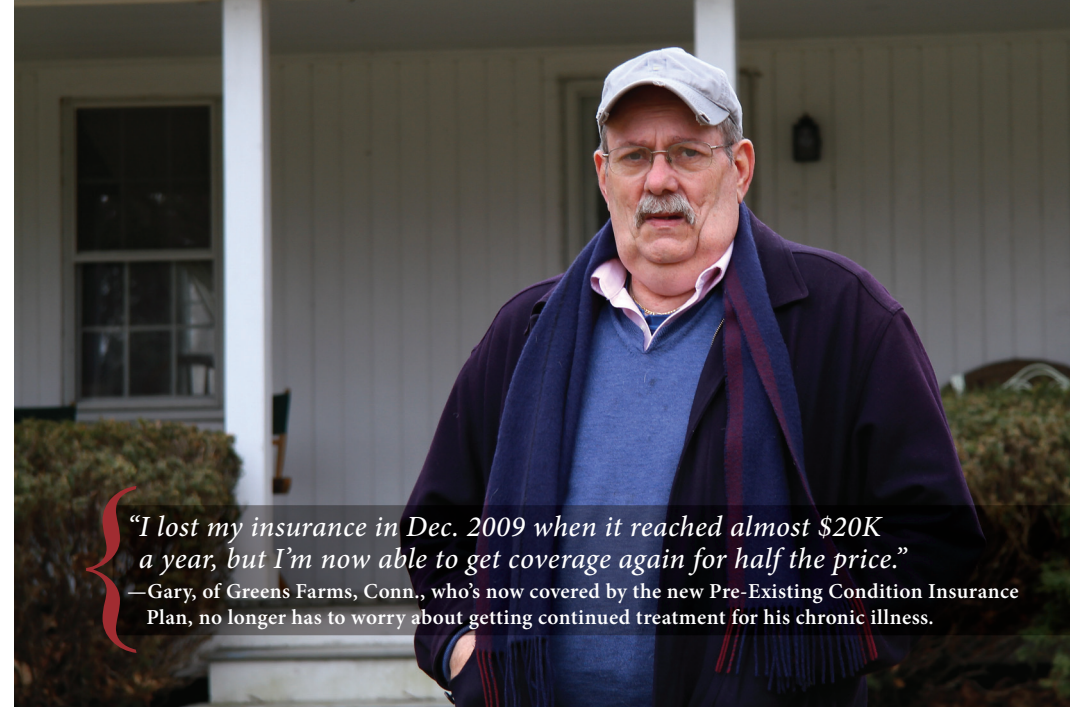
Extending health coverage to teenagers and young adults

How it works:

- Children up to age 26 can remain on a parent's health insurance plan.
- Your employer can't charge a different health insurance premium for your adult children than it does for your younger children.
- or he required to live with you, or be unemployed, unmarried, or a student.
- Until 2014, if you're in a "grandfathered" plan, your child only qualifies if he or she does not have an offer of health insurance through an employer.

The fine print:

- Your child does not need to be financially dependent on you. Nor is she
- Coverage of children up to age 26 does not extend to a spouse or a child of your adult child.



"I lost my insurance in Dec. 2009 when it reached almost \$20K a year, but I'm now able to get coverage again for half the price."

—Gary, of Greens Farms, Conn., who's now covered by the new Pre-Existing Condition Insurance Plan, no longer has to worry about getting continued treatment for his chronic illness.

Plans for people denied for pre-existing medical conditions

How it works:

- Coverage is available through the new Pre-existing Condition Insurance Plan (PCIP) if you've been uninsured for at least six months and have been denied coverage because of a pre-existing condition.
- Premiums vary by age (but not by health status) and are tied to average rates for healthy individuals in your state.
- www.PCIP.gov will link you to the program in your state.
- Premiums are not based on income, so a PCIP may still be unaffordable for some.

DO YOU HAVE A TAX-FREE HEALTH SAVINGS ACCOUNT?

Starting in 2011, you must have a prescription, even for over-the-counter medications, to purchase drugs through a tax-free Health Savings Account or Flexible Spending Account.

But you can still use your tax-free account to pay for expenses like deductibles, co-pays, and services that your health plan doesn't reimburse you for such as dental care or eyeglasses.

The fine print:

- Your costs will vary by state, but all options include comprehensive coverage with no out-of-pocket costs for preventive care.



"Allowing us to keep him on our insurance until 26 came at the perfect time."

—Lori, of St. Louis, Mo., who can now keep her son who suffers from celiac disease covered while he finishes college.

New resources to help you get coverage

Consumer Assistance Programs:

- Federal grants are helping 35 states provide hands-on assistance to more people looking for coverage.
- You can get help finding insurance, filing complaints, and learning about your rights.
- Find your state's program at www.healthcare.gov/law/provisions/cap/index.html.

New website at www.healthcare.gov makes shopping easy:

- Find out which private insurance plans, public programs, and community services are available to you.
- Easily compare prices and coverage options in your area.

Medicare Changes

Medicare is our nation's health-care program for seniors and people with disabilities, funded with taxpayer dollars. Some 36 million Americans are covered by traditional Medicare, and 11 million more are enrolled in private Medicare Advantage plans, which receive federal funding. About 4 million Medicare enrollees will fall into the "doughnut hole" in 2011 because they had drug expenses over \$2,530.

How it works:

- **No-cost preventive services:** Traditional Medicare beneficiaries no longer have to pay any out-of-pocket costs for preventive services such as mammograms, colonoscopies, immunizations, and annual physical exams.
- **Drug discounts:** If you fall into the "doughnut hole" and have to pay full price for your drugs, you will get a 50% discount on brand-name drugs and a 7% discount on generic drugs in 2011. These discounts will increase each year until the doughnut hole is completely eliminated by 2020.
- **Better pay improves access to primary care providers:** Doctors, nurse practitioners, and physician assistants will receive a 10% bonus for providing primary care. General surgeons in underserved areas will also get a 10% bonus.
- **More resources to fight fraud:** New rules go into effect to keep bad medical providers and suppliers from participating in the Medicare system, and new resources will beef up enforcement against those who abuse Medicare.



The fine print:

- **No-cost preventive services:** Medicare Advantage plans don't have to offer this new benefit, but many of them already do.
- **Medicare Advantage changes:** The extra Medicare payments that private Medicare Advantage plans have been getting will phase out over the next several years, starting in 2011. That may change your benefits or out-of-pocket costs if you are in one of these plans. But 76% of Medicare recipients won't be paying these extra costs, and Advantage plans that provide high-quality care will get bonus payments.
- **Seniors with large incomes will pay more for Part B:** If your individual income is more than \$85,000, or \$170,000 for couples, you will pay more for your monthly premium for doctor/outpatient care (known as Part B). A senior making more than the limits will pay premiums between \$161.50 and \$369.10 a month. In 2011, a senior under the limit will pay between \$96.40 and \$115.40. Starting in 2011, premiums for prescription drugs (Part D) will also be linked to those income levels.
- **For more information:** Go to Medicare.gov



"I found out I'm eligible for a 35% tax credit for the premiums I pay for my employees, which makes it easier to keep offering coverage."

—Ed, owner of Franklin Fitness Center in Franklin, N.C., who provides insurance to his employees but has struggled with annual rate increases.

Changes For Small Employers

Small-business tax credits

How it works:

- Employers can receive a tax credit for up to 35% of what they spend on coverage for employees (25% for nonprofits). On Jan. 1, 2014, this tax credit increases to 50% (35% for nonprofits).
- Businesses must have fewer than 25 full-time workers, pay average salaries under \$50,000, and cover at least 50% of the employees' premiums.

The fine print:

- Premiums for small-business owners and their families do not qualify for the tax credit.
- Tax credits vary; check out details at www.irs.gov/pub/irs-utl/3_simple_steps.pdf.

New reporting requirements

How it works:

- To help pay for health reform, new rules increase tax compliance by requiring businesses to report to the IRS payments for goods and services in excess of \$600.

The fine print:

- This tax change is often referred to by the name of the form typically used to report these payments, Form 1099.
- Pending legislation seeks to repeal or alter this provision. It's estimated that full repeal would result in approximately \$19 billion in lost revenue between 2012 and 2022.

New Help for Health-Care Costs

Premiums for medical care, not bureaucracy

Almost half of consumers who buy their own insurance are in plans that spend more than 25% of every premium dollar on administrative costs.

How it works:

- Starting in 2011, many insurance companies must publicly report how much they spend on health-care costs and on administrative costs.
- If you get your insurance through a large employer or other large group, your insurer must spend at least 85% of premiums on medical care or rebate the difference to you.
- If you are covered through a small employer or buy insurance on your own, insurers must spend at least 80% of premiums on medical care.
- Rebates owed on 2011 premiums must be paid by August 2012.

The fine print:

- Ask your employer whether your health insurance is self-funded. Those types of plans don't have to meet this new threshold, but most already do.
- Some states where insurers have very high administrative costs may ask for the new standard to be phased in. Check with your state insurance department to find out if your state has been granted a waiver.
- Employers and insurers that offer policies with very limited coverage may be given at least an extra year before being subject to this rule.

Justifying rate increases

States are responsible for reviewing health insurance rate increases. But many states don't closely examine an increase to make sure it is justified.

How it works:

- Starting in 2011, insurers must publicly post and justify a rate increase of more than 10% for policies covering individuals or small businesses.
- States will determine whether the increase is unreasonable based on health-care costs and other factors. States can reject rates if their laws give them authority to do so. If states can't make that determination, the federal government will.

The fine print:

- This applies only to non-grandfathered plans and does not give states or the federal government new authority to reject unreasonable increases.
- Increases below this 10% threshold may not be posted – that will be each state's decision. And in 2012, the threshold may vary by state.